MDR Tracking Number: M5-04-4039-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 26, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity is not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On the matters of medical necessity, the office visits (99212 and 99213), therapeutic exercises (97110), hot/cold packs (97010), electric stimulation (97032) and manual therapy (97140) for dates of service 11/12/03 through 12/05/03 **were found to be medically necessary**.

The office visits (99212 and 99213), therapeutic exercises (97110), hot/cold packs (97010), electric stimulation (97032) and manual therapy (97140) for dates of service 03/10/04 through 04/23/04 **were not found to be medically necessary**.

The respondent raised no other reasons for denying reimbursement for the office visits (99212 and 99213), therapeutic exercises (97110), hot/cold packs (97010), electric stimulation (97032) and manual therapy (97140).

On August 16, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97014 for date of service 11/12/03 denied as "A". Per Rule 134.600(h) electrical stimulation does not requirement preauthorization. Per Rule 134.202(b) Texas Workers' Compensation system participants shall apply the Medicare program reimbursement including its coding and billing as of August 1, 2003. This CPT code is not one of the codes recognized by the Centers for Medicare & Medicaid Services. Reimbursement is not recommended.

- CPT Code 99213 for date of service 11/19/03 denied as "A". Per Rule 134.600(h) office visits are not one of the services that requires preauthorization. Therefore reimbursement in the amount of $65.21 ($52.17 X 125%) is recommended.

- HCPCS Code L1906 for date of service 11/03/03. Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Per Rule 134.202(c)(2)(A) reimbursement in the amount of $113.16 ($90.53 x 125%) is recommended.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision is hereby issued this 4th day October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service **06/25/03** through **10/28/03** in this dispute.

This Order is hereby issued this 4th day of October, 2004

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/ms

Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-4039-01
Name of Patient:	
Name of URA/Payer:	Galaxy Health Care Centers
Name of Provider: (ER, Hospital, or Other Facility)	Galaxy Health Care Centers
Name of Physician: (Treating or Requesting)	Alex Riley, DC

September 9, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a foot and ankle injury when hit on the inside of her right foot by a forklift on ___. She was initially seen at a local ER and was immobilized in a soft cast. X-rays were found essentially negative for gross fracture or dislocation. Crutches and pain medications were provided. The patient followed with a Lance Craig, MD, where an MRI was ordered and suggested a possible bone bruise of the calcaneus. A CT scan was also obtained suggesting an accessory ossification center from an old healed fracture, bone island in the calcaneus and soft tissue edema form post traumatic changes. She later presented to an orthopedic surgeon, Charles Domingues, MD, where she was treated conservatively until she was able to resume weight bearing in April of 2003. She was allowed to return to work, without restrictions, on 07/21/03. An EMG is performed by a Dr. Divala which is found essentially negative for neuropathy in the right lower extremity. The patient is apparently seen at Beaumont Bone and Joint Center for physical therapy in June and July and is released form care. The patient is found to be at maximum medical improvement by Dr. Domingues on 09/10/03. The patient goes several months without treatment until she presents to a chiropractor, Dr. Kurt Riley at Galexy Treatment Center on 10/15/03. The patient is diagnosed with internal derangement of the right ankle and prescribed passive and active physical therapy from 10/17/03 through 12/05/03. Dr. Riley apparently refers the patient for pain management assessment with a Dr. Mohamed where she receives additional medications and orders for repeat MRI. The patient is also seen by a Dr. Garrett who prescribes additional medications. On 12/09/03, the patient is seen for designated doctor evaluation by a Roger Moczygemba, MD, and found to be at MMI with 4% WPI. Designated doctor indicates that the patient has achieved a plateau with conservative care and that she should continue with medications and be given a home therapy program. The patient apparently continues with an aggressive physical therapy program with Dr. Riley from 12/12/03 to 04/23/04.

Chiropractic notes from this period suggest essentially no change in patient's condition(s).

REQUESTED SERVICE(S)
Determine medical necessity for office visits (99212, 99213), therapeutic exercise (97110), hot/cold packs (97010), electric stimulation (97032) and manual therapy (97140) for period in dispute 11/12/03 through 04/23/04.

DECISION
Approve office visits and physical therapy modalities through 12/9/03 (date of MMI determined by designated doctor). Deny all other services through date range.

RATIONALE/BASIS FOR DECISION
Chiropractic treatment including office visits and physical therapy modalities do appear reasonably appropriate up to 12/09/03 (date of MMI determined by designated doctor). Medical necessity for ongoing treatments and services (12/12/03 through 04/23/04) **are not supported** by available documentation and show no specific curative, corrective or supportive effect. Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms at 9-12 months post injury. In addition, there appears to be no effort made to establish a home therapy program as recommended by designated doctor.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

2. *Foot and Ankle Injury Management Guidelines,* American Orthopaedic Foot and Ankle Society, Foot Care Interactive, Seattle, WA, April 2001.

3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.

4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, December 2002.

5. American College of Foot and Ankle Surgeons: *Diagnosis and Treatment of Foot and Heel Pain,* American Family Physician, April 15, 2002.

6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.